THE FATHERS OF PSYCHOTIC CHILDREN

A STUDY OF ATTITUDES AND PERSONALITY CHARACTERISTICS OF TWENTY THREE FATHERS OF INPATIENT PSYCHOTIC CHILDREN

A THESIS

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ALEX JAMES NORMAN, JR.

SCHOOL OF SOCIAL WORK

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CHAPTER I

INTRODUCTION

Significance Of The Study

For various reasons during the years of research on the parents of psychotic[1] children, more focus has been placed on the mothers. By and large this has been because the mother has been the central figure in the interrelationship in emotional disturbance. While it is recognized that the mothers of psychotic children have been given much attention due to "focusing attention on the patient's early years, when mother usually forms the significant interpersonal milieu of the child,"[2] it is necessary to understand the father's role, which has been described as having not been adequately appreciated or understood.[3] It is true that mothers of psychotic children pose a problem for psychiatrists, psychologists, and social workers, and that this has caused them to be labeled by writers as "schizophrenogenic"[4] thereby implying that they set up a social matrix for all the children with whom they come in contact and act as a carrier of the illness. On the other hand writers are becoming increasingly aware that "...it is apparent that paternal influences are noxious as frequently as are the

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1 Sometimes referred to as dementia praecox, schizophrenia, or autism.

2 Theodore Lidz, Beulah Parker, and Alice Cornelison, "The Role of The Father in The Family Environment of The Schizophrenic Patient," American Journal of Psychiatry, CXIII (1956), 126.

3 Charles W. Wahl, "Some Antecedent Factors in The Family Histories of 392 Schizophrenics," American Journal of Psychiatry, CX (1954), 668-676.

4 For instance, Lewis B. Hill, Psychotherapeutic Intervention In Schizophrenia (Chicago, 1955).

maternal..."[1] and that statistical findings of such can be of great value to those in the field of human relations.

It may be assumed that the father might have been brought into the limelight earlier had not the depression of the 1930's shifted interest in the psychological aspects of research to that of administering financial assistance.[2] The writer is implying that ten years ago we might have been as advanced as we are now, in the field of research, had it not been for the depression. Fathers of psychotic children have not occupied as prominent a position as the mothers because contacts with the fathers were not sufficiently sustained to have provided the researchers with detailed information about them. Because of placement in an agency that sustains contacts with both parents and because of a desire to uncover information pertinent to the father's personality and his attitudes toward the child's illness, the writer thought this a most opportune time for such a study.

The writer believes the father's role to be equally as important as the mother's, and feels that it is necessary to examine the father's personality and the validity of the various assumptions concerning the fathers of psychotic children. Lidz and Lidz stated that "Study of some of the cases leaves the impression that had there been a stable father...the patient would not have been so seriously affected by the mother's difficulties."[3]

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1 Roosevelt Lidz and Theodore Lidz, "The Family Environment of Schizophrenic Patients," American Journal of Psychiatry, CVI (1949), 332.

2 Florence Hollis, Women In Marital Conflict (New York, 1949), p. 7.

3 Ibid. p. 332.

Gerard and Siegel found 86 per cent of their fathers to be "the weak, immature, quiet, passive, retiring individual..."[1] while Frazee differed as her study found only 30 per cent of her fathers indifferent, negligent, and passive.[2] Kanner and Eisenberg found their fathers to be highly intellectual and aloof.[3]

From consultations with psychiatrists, psychologists, and social workers, I have found the fathers of psychotic children described as rejective, demanding, overprotective, and as having some psychopathological diagnosis. Although no meaningful common denominator has been found, passivity seems to have been the most prevalent.[4] Thus intensive, concentrated research on the subject might uncover some consistency in paternal behavior and attitudes, thereby being of some prognostic value, with reference to the type of personality expected and the type of treatment most desirable.

In addition to aiding the writer in his personal growth and understanding, it is hoped that this study may be used as a working reference source for others in the field of Social Work and its related disciplines.

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1 Donald L. Gerard and Joseph Siegel, "The Family Background of Schizophrenia," Psychiatric Quarterly, XXIV (1950), 62.

2 Helen E. Frazee, "Children Who Later Became Schizophrenic," Smith College Studies in Social Work, XXIII (1953), 125-149.

3 Leo Kanner and Leon Eisenberg, "Infantile Autism," Psychiatry Research Reports, (April, 1957), pp. 55-65.

4 Beata Rank, "Intensive Study and Treatment of Pre-School Children who Show Marked Personality Deviations, or 'Atypical Development,' and Their

Purpose Of The Study

The purpose of this study is to describe the attitudes and personality characteristics of fathers of psychotic children in an effort to determine if there is a characteristic profile and/or common denominator of attitudes and personality characteristics found in the fathers of psychotic children.

Method Of Procedure

The writer believed that in order to effectively make a study that would throw light on a part of the father's personality as it relates to the psychotic patient, a careful examination of inpatient intake records would suffice. At Eastern Pennsylvania Psychiatric Institute, Children's Unit, the father, mother, and child have different histories recorded separately. At the time of the study there were twenty-seven inpatient children, of whom twenty-three were psychotic (schizophrenia, dementia praecox, and autism).

The intake procedure consists of no less than three interviews with each parent, or of as many interviews as are needed to get an accurate description of personality by the psychiatrist, psychologists, and social worker. The intake interviews contain all background information on the family, the psychosociological evaluation, and treatment recommendations.

The case study method was applied to the case histories of twenty-three fathers of psychotic children with intentions of detecting evidence of the presence or absence of certain personality characteristics. The personal-

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Parents," Emotional Problems Of Childhood, ed. Gerald Caplan (New York, 1955), p. 491; E. A. Ellison and D. M. Hamilton, "The Hospital Treatment of Dementia Praecox," American Journal of Psychiatry, CVI (1949), 454-467; L. Hajdu-Grimes, "Contributions to the Etiology of Schizophrenia," Psychoanalytic Review, XXVII (1940), 421-438.

ity characteristics were chosen from literature in books and journals (see bibliography), conferences with psychiatrists, psychologists, and social workers, and used as a frame of reference for constructing a schedule which would present a clear picture of attitudes and personality characteristics desired.

Two independent raters were used to apply the use of the schedule so as to attain some measure of reliability. The raters were trained by the writer in the use of the rating scale, using the cases of four fathers of non-psychotic children as a testing ground. After these cases were rated the scale was revised and explained in more detail for purposes of clarity. After the second training period there was no communication between the raters that might make for agreement on any items. This was done to prevent any distortions in the agreement percentage. The raters were employed at the Institute, one as a full time worker with a master's degree from an accredited school of social work, the other, a student on block fieldwork with five years of social work experience.

The writer felt that in addition to a survey of related literature on the fathers of psychotic children, impressions from members in related disciplines would add to a more balanced perspective in gaining some information on the subject because of their day-to-day contacts with fathers of psychotic children. The information gained on the fathers of psychotic children was considered from a negative and positive point of view, and synthesized in the rating scale below.

Rating Scale

I. A. Attitude Toward Social Worker
Cold ( ) Ambivalent or Variable ( ) Warmth ( )

B. Attitude Toward Patient
Cold ( ) Ambivalent or Variable ( ) Warmth ( )

C. Attitude Toward Patient's Problem
Cold ( ) Ambivalent or Variable ( ) Warmth ( )

II. Tendencies Toward Dominance-Submission
Passive ( ) Intermediate ( ) Active-aggressive ( )

III. Attitude Toward Protection of Patient
Overprotective ( ) Accepts Capacity ( ) Underprotective ( )

IV. Attitude Toward Strictness-Permissiveness
Demanding and Restrictive ( ) Permissive ( ) Overpermissive ( )

V. Emotional Expression
Restricted ( ) Expressive ( ) Histrionic ( )

VI. Psychopathological Diagnosis

The writer set himself up as the first rater and rated the two raters on the basis of agreement or disagreement with himself. The original intention was for the raters to apply the scale to the total sample. However unavailability of time necessitated narrowing the number down to ten. The writer then rated the remaining cases on the basis of the agreement percentage reached in the ten cases rated jointly.

The percentage of agreement between the writer and the second rater was 85.7 per cent; between the writer and the third rater, 61.4 per cent; and between the second and third rater, 50 per cent, giving an average agreement percentage of 65.7. This represents truly favorable results since it is the expectation of most researchers to attain agreement percentages in the 40's and 60's.[1] The agreement percentage was inflated by a tendency for the

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[1] Conference with Dr. Justin Aronfreed (Senior Research Fellow at Eastern Pennsylvania Psychiatric Institute, Children's Unit, Philadelphia, Pennsylvania, December, 1958).

raters to see the fathers on one side of the scale. However, there was a presentable amount of variation in the choice of characteristics.

Fathers were rated on the presence or absence of attitudes and personality characteristics such as passivity, aloofness, warmth, rejective attitudes, ability to emote, and psychopathological diagnosis, the latter taken from the results of the psychological tests. Assisting the major plan of presentation was the library method in that theoretical material, published and unpublished, was used to substantiate the findings of the study.

Scope And Limitations

This study is limited to twenty-three cases obtained from the social service files at the Institute and attempts to throw light on only a part of the fathers' personality, that which relates to his attitudes toward the psychotic child. The study is concerned then, with the attitudes of the male parent of the psychotic child and any indicators of effective as well as defective ego functioning, with reference to paternal attitudes toward the child.

In any such study there are limitations which the reader should be given the benefit of knowing. The following are those that have been detected by the writer. The presentation is one-sided in that the study lays emphasis on the father's personality and his attitudes toward the psychotic patient. A study with such a small sample as twenty-three makes its usefulness suggestive rather than conclusive.

In the intake records some workers wrote in-process and others summarized. Since both types of recordings were used, in some cases the accuracy in describing personality was only as reliable as was the worker's accuracy in recording that which actually transpired.

Location Of The Study

The material for the study was taken from the records of the Eastern Pennsylvania Psychiatric Institute, Children's Unit, Philadelphia 29, Pennsylvania.

CHAPTER II

History OF THE AGENCY

The Children's Unit of Eastern Pennsylvania Psychiatric Institute is a 24 bed residential facility and outpatient clinic for treatment of emotionally disturbed children and their families. Upon these treatment programs are based the extensive research and training for which the Institute was created.

The Institute, which is under the direction of Robert C. Prall, M.D., was established by an act of the Legislature of the Commonwealth of Pennsylvania and was dedicated on May 16, 1956 to the purposes of research, training, and healing in the field of mental health. In addition to the Children's Unit, the Institute contains an adult unit with 110 beds, a large adult outpatient clinic, a department for research in the basic sciences related to mental health, and all the necessary maintenance facilities.

As set forth in the enabling Act, the Institute is located in the immediate vicinity of Women's Medical College, one of Philadelphia's five medical schools with which it is affiliated, and within easy traveling distance of the remaining schools. The Medical Advisory Board of the Institute is composed of professors of psychiatry, and the Board of Trustees includes representatives of these Medical schools. Administratively, the Institute is responsible to the Department of Welfare of the Commonwealth of Pennsylvania, which supplies the operating funds.

In view of the tremendous shortage of trained personnel in all the disciplines working with disturbed children, an essential part of the Institute's program is focused on training a large number and variety of people.

Residences in child psychiatry are available to psychiatrists who have completed their training in basic psychiatry. This is a two year program in which the psychiatrist develops, under the supervision of the training staff, skills in the diagnosis and treatment of disturbed children and their families, familiarity with the community resources and educational facilities, and the operation of the various disciplines included in the therapeutic team.

Social work students are given an opportunity to work with parents of disturbed children under the guidance of highly trained personnel to learn the role of the social worker in the therapeutic team.

Trainees in clinical psychology are afforded closely supervised experience in their role as members of the team and in the use of psychometric and projective test materials.

An inservice training program is provided for child care and nursing personnel who work in the residential units with the children. The other members of the team include teachers and occupational therapy workers. Plans for student placement in these disciplines are also underway.

The research program is an integral part of the clinical functioning in both the inpatient and the outpatient departments of the Institute. In general the research interests include sociological, biochemical, psychological, psychodynamic, and psychotherapeutic approaches to a variety of emotional disorders of childhood. The research and training programs are the determinants of the intake study in the Children's Unit.

All the various professional disciplines work together as a coordinated team, with each person carrying out his separate function; integration is

accomplished by means of team meetings and conferences. It is the social worker's job to act as coordinator of the team, serve as therapists for the parents, and in some cases the children, know the community resources and educational facilities, and gather social history information and present a formulated diagnosis of this information at intake conferences. The social worker also participates in case presentations, research conferences, and research projects.

In treatment programs offered to the families of the disturbed children who are referred from the various community agencies, the emphasis is placed on meeting the individual needs of the child. Each child who is referred is given a careful diagnostic evaluation on an outpatient status by means of psychiatric, psychological, and sociological evaluation of his family and cultural setting. If the child is accepted for treatment the parents are also required to participate in therapy because of the belief that the child's disturbance is an outgrowth of difficulties in the parental relationship. Each participating member has a separate therapist, either a psychiatrist, a social worker, or a psychologist. The parents are given weekly individual interviews and separate records are kept for each.

In addition to the above mentioned services, parents on the residential waiting list are offered group therapy sessions headed by a resident psychiatrist. These sessions are held bi-monthly and provide an opportunity for various parents to gather in discussion about their children and their many feelings about their emotional disturbances.

After this careful diagnostic evaluation, the appropriate method of treatment is decided upon and offered to the family at a Family Conference. The fee the family pays is determined by their income and number of depen-

dents, based on a sliding fee scale. Depending on the nature of the problem treatment is offered on an outpatient basis, a day-care basis, or 24-hour residential care. The services of the Institute are available only to residents of Pennsylvania.

CHAPTER III

CHARACTERISTICS OF THE STUDY SAMPLE

This relatively small sample consisted of 23 fathers of a group of resident psychotic children, 19 boys and 4 girls. The ages of the children of these fathers ranged from 5 to 13 years. The father's ages ranged from 30 to 51 years. This group, made up of 21 whites and 2 Negroes, had an educational range of from completion of seventh grade to completion of college. Fifteen of the fathers had gone to college but only 5 obtained degrees; 4 completed high school; and 4 did not get a high school education. However most of the fathers possessed superior intellectual capacity as 15 were tested as such; 6 tested on a bright normal or low superior level; and 2 tested on a normal level.

The occupations of the fathers ran the gamut of middle class employment. Represented in this group were 2 truck drivers, 2 artists, 2 clerks, 2 servicemen, 2 laborers, 3 small businessmen, an insurance salesman, an industrial designer, a manufacturer, a store manager, a draftsman, a taxi operator, a maintenance supervisor, an auto mechanic, a butcher, and a sales manager.

The group of fathers in the study had other children who were not psychotic, many of them had children of both sexes. The presence of boys and girls in the sample group indicated that the illness was not confined to a particular sex. The group included a variety of religious faiths so seemingly this was not a factor. There was no confinement to any one race either as both white and Negro were represented in the sample.

The education of these fathers is to be contrasted with the findings of

Kanner and Eisenberg,[1] in which they found that a high percentage of the fathers in their study possessed college degrees and were highly intellectual. A considerable number in this study had attended college but relatively few had college degrees. However 15 of these fathers were tested as having superior intellectual capacity, which seems to confirm the intellectual aspect of Kanner's and Eisenberg's study. The fact that 6 possessed a bright level of intellectual capacity and the 2 remaining were average, seems to further substantiate this theory. Although most of the fathers did possess the intellectual capacity, the psychological tests results showed that few, if any, were performing at their full potential. If these fathers had not been involved in personality difficulties, they would have probably been operating at a higher level.

Findings

The results of rating these fathers according to the scale were compiled and the following information was yielded. Fifteen fathers were warm and accepting of the social worker, 5 were ambivalent or fluctuated between warm and cold, and only 3 were cold or aloof. Twelve fathers were warm and accepting of the patient, 9 were ambivalent, and only 2 were cold or aloof. However in their attitudes toward the patient's illness, the tendency was for these fathers to lean toward the cold, distant side as 9 were cold or aloof, 12 were ambivalent, and only 2 were warm and accepting of the illness.

In the dominance versus submission category the tendency was to lean toward passivity as 13 of the fathers were passive, 6 were in the interme-

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[1] Leo Kanner and Leon Eisenberg, op. cit., pp. 55-65.

diate range, and only 4 showed aggressive behavior. Psychological tests, which supplemented the rating scale, showed the presence of passive traits in all of the fathers. One of these rated the description of a "generally mature, well-adjusted individual with passive dependent traits."

The attitude of the fathers toward the protection of the patient was that of accepting their children's capacity and allowing them the use of self through supervision. Sixteen of these fathers were so considered, 4 were underprotective, and only 3 were overprotective.

In their attitudes of strictness and permissiveness, 14 fathers were permissive of their children's behavior, permitting freedom of expression, but also setting limits. On the other hand, 6 were demanding and restrictive, and only 3 were overpermissive, exerting no control and failing to set limits for their children.

Perhaps the most outstanding trait was in the fathers' ability to emote or in the category of emotional expression. Eighteen of the fathers were restricted in their ability to emote, 5 were expressive, and none possessed the capacity for lability. In order to be rated expressive there had to be a show of affect with a willingness to talk about feelings.

Additional Findings

The additional findings were discovered in a review of the psychological tests results (the parents are given a battery of psychological tests during the intake procedure). A review of these tests revealed psychopathological behavior in most of these fathers. There were instances where there were no psychological test results. This occurred one time, on one other there was no diagnosis, and still another carried no diagnosis be-

cause the behavior did not warrant one. In all 20 of the total sample had some personality disturbance. Within the groupings of these fathers there were 5 different descriptions of deviant behavior, of which I have group accordingly:

(1) Inadequate Personality: Three fathers were in this group, characterized by a tendency to be inadequate in their friendships, economic, occupational, and emotional adjustments. They were not necessarily inadequate in their intellectual ability or physical make up, but were responding inadequately to society's demands.

(2) Schizoid Personality: One father fitted this description of a person not overtly psychotic but possessing some of the personality traits of the schizophrenic. This type is characteristically aloof, cold, and emotionally detached.

(3) Chronic Schizophrenia-paranoid type: The one father who fitted this description was a borderline psychotic with decompensating defenses. This type of individual can function without the presence of a psychosis because his defenses have been partially adequate for situational use.

(4) Obsessive Compulsive Reaction: Seven of the fathers fell into this category and were extremely emotionally detached. Inwardly they were childish, sadistic, and rebellious in nature, but through the use of their defenses, presented just the opposite picture.

(5) Passive Dependent Personality: Eight of the fathers fell into this group and were characterized by immature reactions in which failure to attain mature emotional development of the personality is manifested in the passivity and unrealistic dependency of these individuals.

Additional findings also revealed problems of sexual identification in

most of these fathers. A review of the psychological tests results showed that 19 of the fathers were bothered with problems of sexual identification. These ranged from an unconscious level to a conscious level. Accompanying this problem were homosexual drives, many of them severe, which showed that these fathers were not comfortable with their masculinity.

CHAPTER IV

ANALYSIS OF FINDINGS

In their attitudes of warmth displayed toward the social worker and the child, these fathers are also contrasted with the typical cold, aloof, distant character described in other studies.[1] The display of warmth by these fathers is considered a positive attitude and nearer to the norm for what would be expected of a father. However, the absence of an attitude of warmth toward the patient's problem indicated the tendency for these fathers to be warmer in their relationships away from the family. There were very few who were cold toward the worker and the patient, 3 and 2 respectively, yet when the patient's problem was introduced there seemed to be an attitude in which the fathers sought to emotionally detach themselves, and their feelings, from the problem. This probably accounts for the little warmth displayed in this area. Many sought to verbally deny the presence of emotional disturbance in their child, or shift whatever blame there was to the mother. A review of the cases suggests that this is a result of the guilt feelings, among the many mixed feelings the parents of psychotic children have.[2] The tendency for these fathers not to accept the patient's illness or to be ambivalent about it, and many were, suggests a fear of their involvement in the total situation. Typical of some of their verbalizations are the following, taken from case material.

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1 Beata Rank, op. cit., p. 491; Leo Kanner and Leon Eisenberg, op. cit., pp. 55-65.

2 George Shugart, "A Casework Program For Parents of Psychotic Children," p. 5 (mimeographed).

Mr. Smith's son had been diagnosed by two other clinics as being autistic. In addition the child had exhibited much bizarre behavior. At 4 years old he could not talk and his hearing seemed intermittent. Mr. Smith said he saw nothing wrong with the boy except that he was just slow to learn. He felt that if his wife would ease up on her limiting the child, he would grow out of it. Mr. Smith cited many instances where he was also slow to walk, talk, and play with children, but grew out of it when his mother stopped being controlling of him. Upon attempts to solicit feelings about his son's illness, Mr. Smith only compared his behavior with someone who was "Worse off."

Mr. Ford's son had a childhood psychosis marked by an inability to control himself. In addition he exhibited the symptom of withdrawal. He said his son was the least sick of those on the ward and conveyed this opinion to the child. He felt that his son was a little disturbed but would be cured in a matter of months. He felt that we should help his son maintain his high intellectual ability and teach him to conform regardless of his emotional state. Mr. Ford felt that the problem was in his wife's inability to raise children. According to him, he knew how to raise children and never had any trouble with his son, however his wife did.

These are typical instances in which the fathers could not accept the patient's illness and, in other cases, would suggest to the child that the Institute was a "School" or "a place where you learn how to behave." On the whole it was anything but a hospital for emotionally disturbed children. On the basis of 10 other cases that gave similar evidence, the writer believes this is typical of their tendency to find fault in the mother so as to decrease guilt over their own involvement in the child's emotional disturbance.

The fathers who were ambivalent toward the worker, the patient, and the patient's problem raise the question as to the importance or significance of the ambivalent factors. While this is still puzzling to the writer, it also points out the tendency for these fathers to want to assume an in-the-middle-of-the-road position rather than be pro or con. The writer believes that a fear of involvement also plays a part of some importance in this

indecisive struggle for identification. It would seem that the inconsistency in paternal attitudes toward relationships and behavior is confusing to the child. Another writer[1] found a similar type of father whose demands depended upon his neurotic or psychotic behavior needs. However, this is no attempt to identify this father with the type found in other studies, but merely an attempt to substantiate my analysis of the inconsistent behavior.

An outstanding character trait was the passivity found in these fathers. This seemingly confirmed the belief that the fathers of psychotic children are passive in nature.[2] While 13 of the total sample were rated as passive, the psychological tests results, which supplemented the rating scale, revealed passivity in all but one of these fathers. The one absentee was a father who possessed a few passive traits but was otherwise a mature individual. The fathers who fell into the intermediate range were nearer to the norm for expected behavior. The passive fathers raised a question in the writer's mind as to what type of male identification were they provided in childhood, since the child who grows up with "a grossly maladjusted father or father figure will undoubtedly have serious difficulties maturing properly."[3] In this context I use male identification for both sexes, for not

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1 Theodore Lidz, Beulah Parker, and Alice Cornelison, op. cit., p. 128.

2 Beata Rank, op. cit., p. 491; E. A. Ellison and D. M. Hamilton, op. cit., pp. 454-467; L. Hajdu-Grimes, op. cit., pp. 421-438.

3 Theodore Lidz et al. "The Intrafamilial Environment of the Schizophrenic Patient: I The Father," American Journal of Psychiatry, XX (1957), 333.

only do boys need male identification, but also girls. This gives the child an answer to the question of "who am I?" in addition to aiding in the oedipal resolution.

A review of the case material showed that few, if any, of these fathers had a wholesome relationship with their fathers that could counterbalance the prominent role played by their mothers. As a result there was a lack of adequate identification from which to form the model for an adult role of husband and parent. This occurred regularly throughout the 18 cases reviewed. The 5 remaining cases did not have sufficient material to bear this out further. The following is the typical relationship.

> Mr. Alm is a 43 year old father of three. His father was the recipient of much abuse from Mr. Alm's mother. If something went wrong in the house, his father usually received the blame. Mr. Alm's mother was the dominant figure, managing the household, money affairs, and disciplining the children. Mr. Alm wondered why his mother was always at odds with his father. Mr. Alm's father served as the breadwinner and was just a man around the house, reacting passively to the mother's frequent attacks. She explained, in the father's presence, that it was because he did not warn her of the sexual angle in marriage. Mr. Alm and his father only listened quietly. When conflict arose around his schooling, Mr. Alm's mother settled it by saying he would become an artist, although his father wanted him to learn a trade. The result was that he attended an art school and became a successful industrial designer.
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> Mr. Bek is a 36 year old father of three. His father died when he was 3 years old. His mother remarried an English research chemist when Mr. Bek was 9. His step-father was never close to him, and they had no mutual interests. They never did things together, nor did his step-father orientate him on sex. Mr. Bek felt there was distance between the two because of his step-father's English heritage. According to Mr. Bek he was expected to obey and learn naturally. The father figure turned out to be an alcoholic and was never around the home. Consequently the mother managed the money, made all decisions, and did all disciplining while the step-father was at work, or drinking, or both.

Both of these fathers were extremely passive. While these two cases highlight a dramatic occurrence, they are nonetheless typical of the rela-

tionships of these fathers to their fathers. While Mr. Alm was successful as a designer, and Mr. Bek, a success in his profession, it is important to point out that these types of fathers are "...not necessarily inadequate in their work or their friendships, but definitely inadequate in their family adjustments."[1] The first father confessed that he did not know what was expected of him as a father. He thought it was sufficient to provide economic security for his family. The other father was simply overly confused in his relationship with his children. Not only had he turned over disciplinary duties to the mother, but also all management and budgeting duties entirely. It has been pointed out that these fathers are not usually involved in household activities other than giving the child the most severe punishment.[2]

The fathers in the intermediate range were possessors of passivity, but with enough initiative to take over responsibilities sometimes and share in home management. However, again we get a picture of a fluctuating individual who is sometimes passive and sometimes aggressive, but not stable in either role.

The fathers who exhibited aggressive behavior were found to do so out of defense against their passive dependency. They were even inconsistent in their aggressive behavior. A typical example was that of a father who was a roaring lion in the home, yet he was just the opposite on his job. He

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1 Theodore Lidz, Beulah Parker, and Alice Cornelison, op. cit., p. 127.

2 Bertram H. Roberts and Jerome K. Myers, "Schizophrenia in The Youngest Male Child of the Lower Middle Class," American Journal of Psychiatry, CXII (1955), 131.

was content to accept whatever gifts his employer would give him, never asking for a raise or promotion, though appearing competent. When his employer presented him with a year-old automobile, the father assumed an even more passive nature at work, though still aggressive at home. Again this inconsistent behavior is brought to the forefront. This type of father, seemingly, seeks to partially satisfy his dependent needs either in the home or in his relationship away from the home.

In their attitudes toward the child's protection, the fathers were overwhelmingly rated in the intermediate range, permitting the child to be self-reliant and promoting his independence through supervision. This is what would be expected of a father who adequately fills his role, and it is the writer's thinking that this would not be detrimental to the child's personality development.

The few fathers (4) who were underprotective of the child and did not support him in situations of stress might have been acting out their resentment of the child. The fact that all were male patients suggests the possibility that the fathers were of the same type found by Lidz,[1] whereby there is described, a hostile father in rivalry with the son for the mother's attention and affection. This type does not intervene with the mother in raising the child but, through this unhealthy attitude, prohibits her doing so.

The still fewer 3 fathers who were overprotective of the patient were exhibiting, in a more subtle fashion, their resentment of the child since

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[1] Theodore Lidz, Beulah Parker, and Alice Cornelison, op. cit., p. 129.

the overprotectiveness represents a form of rejection. The writer belives the fathers felt guilty over their unconscious rejection and sought to compensate by literally sheltering the child. Levy[1] associated overprotection with sexual maladjustment, and inferred that a wife devoted to her husband could not become an exclusive mother. The writer says the same in reverse, a husband devoted to his wife cannot become an exclusive father. The writer further feels that he must explain the paternal overprotection in reverse because of the puzzling aspect of what is its significance.

In attitudes of permissiveness, the fathers were overwhelmingly permissive of the patient's behavior, accepting his capacity and making no unreasonable demands of him. The writer feels that this was an example of the complementary aspect of passivity in these fathers, especially when one takes into consideration, the overprotective and controlling mothers found in other studies.[2] The fact that some of these fathers set limits for the child is again indicative of their inconsistent behavior.

Those fathers who were demanding of the child appeared sadistic, in view of the child's inability to perform on a normal level. This type of father was also found in a study by Lidz.[3] These fathers' inconsistent

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1 David M. Levy, Maternal Overprotection (New York, 1943), pp. 113-209.

2 For instance, Lewis B. Hill, Psychotherapeutic Intervention In Schizophrenia (Chicago, 1955); Yjro O. Alanen, The Mothers of Schizophrenic Patients (Copenhagen, 1958).

3 Theodore Lidz, Beulah Parker, and Alice Cornelison, op. cit., p. 128.

demands are also unrealistic and hostile, and seem to be a projection of their own wishes. This is seemingly an effort on the part of these fathers, to attain success through their children, thereby compensating for their own feelings of inadequacy.

The fathers who were overpermissive and set no limits for the child are closely akin to those who were underprotective in their manner, but are not necessarily the same ones. Again the child is literally on his own, possibly because the father has assumed a hands-off policy. This seemingly takes place because the guilt over the resentment of the child results in the father's being too permissive of the child.

The ability of these fathers to emote was another trait that seemingly deviated from normal behavior. Only 5 of the total sample were expressive of their feelings and showed some attempt to discuss and understand them. The remaining 18 were restricted in their emotional expression and either denied feelings, suppressed or repressed them, or intellectualized conversation in an effort to decrease chances for a discovery of their feelings. None of the fathers were rated as labile, and the psychological tests results confirmed the ratings in that none of the fathers possessed the capacity for lability. These fathers were extremely emotionally detached, and presented a number of reasons why. One father confessed that he had never been accustomed to telling others how he felt or even admitting to himself that he had feelings. Another said it was a common practice in his family not to disclose feelings, and that they were understood to be present but never expressed. Still another contended that he had always been the easy-going type who never let anything bother him. The latter answer was the

most frequent given.

In the same manner that Eisenberg[1] found that these types of fathers discussed their children's symptoms in detached fashion, they were also detached when it came to their involvement. This accounts for the restricted manner that arises as a defense against their involvement. As a result these fathers present a picture of individuals who have integrated a distant, intellectually, emotionally alien attitude.

Of the total sample, only 3 fathers escaped a psychopathological diagnosis, one because there was no psychological tests results in the record, another because his behavior did not warrant a diagnosis, and another because his behavior was described but not diagnosed. Their behavioral categories ranged from character disorders to borderline psychoses. Twenty of the fathers possessed personality disturbance, which seems to substantiate the belief that there is usually severe psychopathology in one or both parents of psychotic children.[2] With the presence of such neurotic and prepsychotic behavior, it is easily seen that it would be extremely difficult for these individuals to adequately fill the roles of husbands and fathers.

Additional Findings

The psychological tests results also revealed the fact that 19 of

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[1] Leon Eisenberg, op. cit., p. 718.

[2] Roosevelt Lidz and Theodore Lidz, op. cit., p. 332.

these fathers were confronted with problems of sexual identification. This seems to indicate that their growth into an effeminate role was not impeded by their fathers or father figures. The problems ranged from the conscious to the unconscious level, but it was evident that these fathers were engaged in an indecisive struggle to identify with one of the two sexes. As was the case with these fathers, who are frequently insecure in their masculinity,[1] there were severe homosexual drives and distortion of heterosexual relationships. Although most of this material was secured from the psychological tests results, there were cases where the problem area was admitted to the social worker and confirmed by the psychological tests as is illustrated in the following case material.

> Mr. Charles was discussing his relationship with his child, Bill. He said he enjoyed playing with his son, and that at each termination of play he would accompany his son to his room and tuck him in bed. He also said when Bill went to the bathroom, he could not refrain from peeking at him through the keyhole. He did not know why he did this, but admitted that he gained some pleasure in doing so. In subsequent interviews he admitted that it was his son's penis which held his interest.

> Mr. Downs admitted sexual problems while talking of his sexual relationship with his wife. He told the social worker that he felt guilty after having sexual intercourse with his wife. This frightened him because he did not understand the implications. He added that he only had sexual intercourse twice a year because his wife was worried about their child's illness, and he did not want to bother her while she was upset. In subsequent interviews he admitted a compulsion for watching other men's penises when entering a public toilet.

Though these cases are heightened and dramatic, they were typical of

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[1] Theodore Lidz et al., "The Intrafamilial Environment of The Schizophrenic Patient: IV Parental Personalities and Family Interaction," American Journal of Psychiatry, XXVIII (1958), 342.

features found in most of these fathers. The psychological tests results showed that these two cases, and 17 others, possessed severe homosexual drives and were extremely uncomfortable with heterosexual relationships, preferring alliance with less threatening males. In the case of Mr. Charles, it seems that his relationship with his son was not genuine, but one in which he could satisfy his homosexual desires. In the case of Mr. Downs, it seems that the father sought to decrease his guilt feelings toward sexual intercourse by not indulging so frequently, using as his excuse the fact that his wife was upset by their child's illness. On the basis of the theory that these fathers sought identification with their father, and not finding him the strong one identified with the mother as protection against castration fears, one could see that what Mr. Downs felt might not have been guilt but latent fears of castration. The writer further believes that since the woman is seen as a castrating figure, this enhances these fathers' uncomfortableness with heterosexual relationships.

For purposes of comparison, 10 psychological tests of fathers of neurotic children were reviewed. Only testing the appearance of homosexual drives, results were that only 2 possessed feminine traits, but none to the degree of the fathers of the psychotic children. Since it is a practice of the Institute to test only the parents of psychotic, and severely neurotic children, other psychological tests results were not available. The writer believes that there would be less homosexual drives in the fathers of normals, basing this belief on the findings of other studies, in which the fathers of normals were found to be better adjusted and less pathological in their behavior than fathers of neurotic or psychotic

children.[1]

Conclusions

An analysis of the attitudes and personality characteristics of the fathers of psychotic children reveals the presence of serious personality disturbance, such as varied psychopathological diagnoses and the problems of sexual identification, that prohibits the adequate functioning of these individuals as effective husbands and fathers. This also confirms the belief that psychotic children usually come from homes that include severe psychopathology of one or obth parents.[2] To what degree this personality disturbance contributed to the disharmonies of family life is not indicated, but one cannot deny the fact that it had its influence on the behavior of the mother as well as the child.

There was no father-type who could be labeled "schizophrenic," but there were certain personality characteristics found with remarkable frequency in a majority of these fathers. Among these characteristics were passivity, inability to emote, and inconsistent behavior in relationships. These occurred with such regularity that it is conceivable how writers can believe that these fathers would make it difficult for any mother to ade-

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[1] Marshall R. Jones (ed.). Nebraska Symposium On Motivation, (Lincoln, 1957), p. 155; Jean Block et al., "A Study of The Parents of Schizophrenic and Neurotic Children," Psychiatry, XXI (1958), 387-397; James E. McKeown, "The Behavior of Fathers as Reported by Normals, Neurotics, and Schizophrenics," American Journal of Sociology, LVI (1950), 175.

[2] Roosevelt Lidz and Theodore Lidz, op. cit., p. 332.

quately fill her role.[1] It should not be concluded that the fathers portrayed in this study are unique to families with psychotic children, but it should be said that from this study it seems that there is gross personality disturbance in these parents, as opposed to the parents of normals and neurotics.

However, all of the personality characteristics of these fathers of psychotic children were not negative or detrimental to relationships of life functioning. The permissiveness of the patient's behavior and allowance of self-reliance, through supervision, were admirable traits. The fathers' attitudes of warmth shown the worker and the patient were also admirable.

Hence these fathers of psychotic children possessed both, negative and positive factors in their personality structure. The writer concludes that the combination of the described negative and positive factors is characteristic of these fathers of psychotic children, but that the negative factors outweigh the positive ones. A combination of the positive and negative factors presents a picture of inconsistency in paternal attitudes and behavior.

The writer also concludes that the inconsistent behavior is most significant in that it sets these fathers up as poor models in their roles as husbands and parents. In doing so, these fathers are also inconsistent in their demands of their children. The inconsistency in paternal attitudes

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[1] Theodore Lidz, Beulah Parker, and Alice Cornelison, op. cit., p. 129; Leon Eisenberg, op. cit., p. 723.

and behavior only confuses children, encouraging them to escape to a world of unreality rather than submit themselves to a world of inconstant demands.

The writer's final conclusion is that these fathers of psychotic children were poor male models for two reasons: (1) they were provided with poor male identification during their childhood which ill-prepared them for their adult roles of husbands and parents; and (2) most of the fathers of psychotic children had serious personality disturbances that prohibited, to a marked degree, their effectiveness as husbands and parents. The writer does not wish to conclude that the children's psychotic conditions were due solely to the fact that their fathers, in some instances, might have been inadequate male models for implications are that there are other contributing factors, probably residing in the child.

APPENDIX

SCHEDULE

Identifying Information

Case._____. Age_____. Race_____. Religion_____. Education_____.

Occupation_____. Marital Status_____. Age at Marriage_____fa.

_____mo. Age at birth of first child_____fa.____mo. Age at birth of patient_____fa._____mo. Ordinal position of Patient_____of_____.

Personality Rating Scale

I. Attitudes (cold vs. warmth).
   A. Toward Social Worker.
      1. Cold (aloof, indifferent, distant, cool, not accepting).
      2. Ambivalent or Variable (vacillating, fluctuating).
      3. Warmth (not aloof, warm, accepting, interested).

   B. Toward Patient.
      1. Cold (same as above).
      2. Ambivalent or Variable (same as above).
      3. Warmth (same as above).

   C. Toward Patient's Problem.
      1. Cold.
      2. Ambivalent or Variable.
      3. Warmth.

II. Dominance-Submission Tendencies.

   A. Tendency Toward Passive-submissive (easy going, making little or no decisions in home, following lead of others).

   B. Intermediate (takes initiative himself sometimes, shares in decision-making, sometimes uses guidance and control of others).

   C. Tendency Toward Active-aggressive (domineering, making major decisions, handles money).

III. Attitudes Toward Protection of Patient.

   A. Overprotective (permits little or no initiative, does not allow child to be self-reliant).

B. Accepts Patient's Capacity (allows use of self, permits self expression, but also supervises child.

C. Underprotective (pushes child excessively toward independence, does not offer support and guidance during situations of stress).

IV. Strictness-Permissiveness Attitudes.

A. Demanding and Restrictive (sets high standards of performance, punitive, allows little or no freedom of expression).

B. Permissive (permits freedom of expression but also sets limits, makes reasonable demands of child.

C. Overpermissive (overindulgent, fails to set limits, exerts no control).

V. Emotional Expression.

A. Restricted (withholds feelings, vague attitude, evasive of emotional expression, denies presence of feelings).

B. Expressive (expresses feelings, shows willingness to talk about emotional expression, denies presence of feelings).

C. Histrionic (labile, overexpressive, emotes highly).

VI. Psychopathological Diagnosis.

A. Present.

B. Absent.

C. Description.

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